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# "It Takes a Lot to Get Into Bellevue": A Pro-Rights Critique of New York's Involuntary Commitment Law

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# "IT TAKES A LOT TO GET INTO BELLEVUE"†: A PRO-RIGHTS CRITIQUE OF NEW YORK'S INVOLUNTARY COMMITMENT LAW

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† This quote is attributed to Frederick Covan, former chief psychologist at Bellevue Hospital in New York City, in Mark Harris, *Checkout Time at the Asylum*, N.Y. MAG. (Nov. 16, 2008), http://nymag.com/news/features/52176/. One of the purposes of this Note is to examine, from a legal perspective, the accuracy of Dr. Covan's statement.

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## INTRODUCTION

Involuntary commitment case law continues to demonstrate that mental illness is not only a physical and psychological affliction, but also a de facto legal status.[1] Suffering from or being diagnosed with—that is, being alleged to have—a mental illness makes one eligible for involuntary treatment, including inpatient commitment tantamount in many ways to incarceration.[2] The key difference between incarceration and commitment is that a person must be adjudged beyond a reasonable doubt to have actually committed a crime to be incarcerated for a set period, whereas members of a select, frequently institutionalized class, the mentally disabled, may be confined indefinitely upon a physician's assessment that they may at some future date commit a harmful act.[3] Mental disabilities affect a remarkably broad range of New Yorkers: a recent survey by the New York City Department of Health and Mental Hygiene (DOHMH) found that 430,000 New Yorkers—7.3% of the City's population—suffered from a major depressive disorder, and 200,000 or 3.5% of the City's population suffered from a generalized anxiety disorder.[4]

1. This Note will try to refer to whatever facts courts include regarding the reasons why a person has been committed, in order to give a practical sense of what it "takes" to be involuntarily committed. This is intended partly to support the proposition that otherwise innocuous or sympathetic behavior can become a pretext for "fenc[ing] in . . . those whose ways are different." *See* O'Connor v. Donaldson, 422 U.S. 563, 575 (1975); *see also* Michael L. Perlin, *"Half-Wracked Prejudice Leaped Forth": Sanism, Pretextuality, and Why and How Mental Disability Law Developed As It Did*, 10 J. CONTEMP. LEGAL ISSUES 3, 13 (1999) (remarking that cases and statutes, taken at face value, tell us "virtually nothing" about "how mental disability law is actually applied . . . and why it is applied that way").

2. *See, e.g.*, Humphrey v. Cady, 405 U.S. 504, 509 (1972) (describing involuntary commitment as a "massive curtailment of liberty" requiring due process protection). In addition to losing their freedom from physical restraint, committees lose their First and Fourth Amendment rights as well as have their right to object to medication severely restricted. *See, e.g.*, Cooper v. Sharp, No. 10-5245 (FSH), 2011 WL 1045234, at *8–10 (D.N.J. Mar. 23, 2011) (describing the "limited" rights of involuntary committees to be free from searches and mail screening); *see also* Mills v. Rogers, 457 U.S. 291, 299 n.16 (1982) (involuntary patients' interest in objecting to medication limited by state interests).

3. *See infra* Part I.A.2.

4. *Division of Mental Hygiene*, NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE, http://www.nyc.gov/html/doh/html/dmh/dmh-mental_illness.shtml (last visited Jan. 15, 2013).

Another 6.3% reported "nonspecific psychological distress."[5] Even more troubling, a 2005 DOHMH survey of teenagers found that 9.6% of respondents had attempted suicide within the past twelve months.[6] Under current state law standards, any of these conditions could make one eligible for involuntary civil commitment.[7] State law designates twenty-seven hospitals for inpatient treatment of mental illness under the direction of the Office of Mental Health (OMH).[8] A 2009 report by OMH indicated that 173,682 New Yorkers were receiving treatment in residential OMH programs, including 12,853 in inpatient residential treatment facilities.[9] Despite the fact that mental disability affects an enormous percentage of its population, New York State's statutory scheme for involuntary confinement of the mentally disabled, Mental Hygiene Law Article 9[10] (Article 9) is among the least rights-protective in the country, allocating an enormous amount of discretion to physicians.[11] Periodically, patients and advocacy organizations have challenged this arrangement, but since the Second Circuit found Article 9 facially valid in *Project Release v. Prevost*,[12] District Courts have upheld it consistently.[13]

This Note will examine New York State's involuntary civil commitment statute, Mental Hygiene Law Article 9, in light of developments in the due process case law and scientific literature relating to involuntary commitment since the Second Circuit Court of Appeals last heard a wholesale facial challenge to the statute in *Project Release.* Part I will analyze New York State's commitment law in its constitutional context. Part I.A will analyze the constitutional framework around which New York's statute is constructed, starting with the Supreme Court's foundational rulings in *O'Connor v. Donaldson*,[14] *Addington v. Texas*,[15] and *Vitek v. Jones*,[16]

5. *Id.*

6. *Id.*

7. *See infra* Part I.B. The legal standards are codified in NEW YORK MENTAL HYGIENE LAW § 9.01.

8. *See* N.Y. MENTAL HYG. LAW § 7.17(b) (McKinney 2011).

9. *See PCS Summary Reports—Survey Week 2009*, N.Y. ST. OFFICE MENTAL HEALTH, http://bi.omh.ny.gov/pcs/Summary%20Reports?pageval=prog-res&yearval=2009 (last visited Jan. 15, 2013).

10. N.Y. MENTAL HYG. LAW §§ 9.01–9.63.

11. *See infra* Part II.

12. 722 F.2d 960, 963 (2d Cir. 1983).

13. *See, e.g.*, Kraft v. City of New York, 696 F. Supp. 2d 403 (S.D.N.Y. 2010).

14. 422 U.S. 563 (1975).

15. 441 U.S. 418 (1979).

16. 445 U.S. 480 (1980).

and taking account of more recent developments in cases like *Kansas v. Hendricks*[17] and *United States v. Comstock*.[18] This Note will comment on the police and parens patriae powers that underpin different parts of the Mental Hygiene law, and the due process implications attendant on each. Part I.B will break down the involuntary commitment statute section by section to illustrate how the legislature has attempted to meet minimum due process standards set out by the Supreme Court. Part II will compare Article 9 and the state and federal case law interpreting it with other states' involuntary commitment schemes and rights-protective judicial doctrines that courts interpreting these schemes have adopted. Through this comparison, this Note concludes that New York's commitment scheme is unusually under-protective of the rights of the mentally ill, leaving excessive discretion to psychiatrists and providing insufficient procedural protection, and that the inevitable result is unconstitutional over-commitment.[19] Part II necessarily will revisit *Project Release v. Prevost*[20] in detail, highlighting key areas of the Second Circuit's reasoning that have been so undermined since the case was decided that the decision should be overturned or modified. In light of this conclusion, Part III proposes an increased role for Section 1983 and ADA Title II actions against psychiatrists and institutions. This Note will consider how these case-by-case litigation-based strategies, though not as effective as legislative action to amend Article 9 directly, have the potential to indirectly shape a more protective limiting norm and shield New York's mentally ill from over-commitment.

17. 521 U.S. 346 (1997).

18. 130 S. Ct. 1949 (2010).

19. *See* Ruth E. Ross et al., *A Framework for Classifying State Involuntary Commitment Statutes*, 27 ADMIN. & POL'Y MENTAL HEALTH 341 (1996) (applying a statistical analysis to state mental facility admission rates, and finding that states with more stringent statutory guidelines for involuntary confinement had lower rates of admission). "Over-commitment" is used in this Note as a term of art to refer to the commitment of mentally ill individuals who have been misdiagnosed as meeting the minimum constitutional requirement of "dangerousness to self or others." *See supra* Part I.A.1.

20. 722 F.2d 960 (1983).

## I. ARTICLE 9 AND THE CONSTITUTIONAL LIMITS ON CONFINEMENT

### A. The Federal Framework

Prior to the 1970s, courts played a minimal role in the civil commitment process, leaving the standards and procedures by which patients could be confined against their will largely to the discretion of state legislatures and mental health professionals.[21] In the early 1970s, landmark civil rights cases like *Wyatt v. Stickney*[22] and *Lessard v. Schmidt*[23] ushered in a "de-institutionalization movement"[24] in which state and federal courts, and eventually the United States Supreme Court,[25] began to identify the procedural and substantive rights of individuals diagnosed as mentally disabled. Throughout the 1970s and early 1980s, the Supreme Court enunciated a general framework of minimum constitutional standards that state

21. *See* William M. Brooks, *The Tail Still Wags the Dog: The Pervasive and Inappropriate Influence by the Psychiatric Profession on the Civil Commitment Process*, 86 N.D. L. REV. 259, 260 (2010).

22. 325 F. Supp. 781 (M.D. Ala. 1971).

23. 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1974), *reinstated and enforced*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated on other grounds*, 421 U.S. 957 (1975), *reinstated*, 413 F. Supp. 1318 (E.D. Wis. 1976).

24. *See, e.g.*, Judge Reese McKinney, Jr., *Involuntary Commitment, A Delicate Balance*, 20 QUINNIPIAC PROB. L.J. 36, 37 (2006) (briefly summarizing the movement). According to some commentators, the "de-institutionalization movement" culminated in Congressional action to protect the rights of the mentally disabled. *See, e.g.*, Michael L. Perlin, *"Make Promises by the Hour": Sex, Drugs, the ADA, and Psychiatric Hospitalization*, 46 DEPAUL L. REV. 947 (1997) (discussing the Developmentally Disabled Bill of Rights Act, 42 U.S.C. § 6000 (2006), and the Protection and Advocacy for the Mentally Ill Act (PAMI), 42 U.S.C. §§ 10801–10851 (2006)). While these statutes gesture toward rights protection, they generally do not create privately enforceable rights. *See id.* at 948; *see also* Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 8 (1981).

25. In one of the first Supreme Court cases to deal directly with the constitutional implications of involuntary commitment, Justice Blackmun observed, "Considering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this power have not been more frequently litigated." Jackson v. Indiana, 406 U.S. 715, 737 n.22 (1972) (citing a congressional report from 1961 indicating that, at that time, "90% of the approximately 800,000 patients in mental hospitals in this country had been involuntarily committed"). The *Jackson* Court, which dealt with a federal prisoner challenging his transfer to a mental facility, did not reach the question of substantive qualifications for commitment in the absence of a criminal conviction, but did observe that due process imposed limits on the state's power to confine the mentally ill. *Id.* at 719, 736–38. Justice Blackmun's observation could be seen as "opening the courthouse door to persons with mental disabilities," setting the stage for the subsequent "explosion of litigation" on involuntary commitment. Perlin, *supra* note 1, at 10–11.

involuntary commitment schemes must meet in order to protect those rights.[26] This framework is oriented around two distinctions: first, the distinction between "dangerous" and "nondangerous" mental illness; and second, the distinction between a mentally disabled individual's liberty interests and the general interests of society.

### *1. Substantive limits*—O'Connor*, Addington, and the "Danger" Standard*

The first distinction comes from *O'Connor v. Donaldson*.[27] Kenneth Donaldson's father committed him to the Florida State Hospital at Chattahoochee based on "scanty" evidence that Donaldson suffered from "delusions," under a Florida statute that authorized commitment of anyone adjudged "incompetent by reason of mental illness."[28] Donaldson repeatedly but unsuccessfully demanded his release throughout nearly fifteen years of involuntary confinement before finally bringing a Section 1983 claim against the hospital for damages and injunctive relief.[29] Upholding Donaldson's claim, the Supreme Court held that "a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[30] Because the trial court had determined that Donaldson, even if mentally ill, was not dangerous to himself or others, the hospital had violated his constitutional right to freedom.[31] Although this holding establishes the substantive right of "nondangerous" mentally ill (or allegedly mentally ill) individuals to live in "the private community,"[32] the *O'Connor* Court expressly declined to decide "whether, when, or by what procedures, a mentally ill person may be confined by the State on any of the grounds which . . . are generally advanced to justify involuntary confinement of such a person—to prevent injury to the public, to ensure his own survival or safety, or to alleviate or cure his illness."[33]

Although *O'Connor* left the substantive and procedural requirements of lawful involuntary commitment to be resolved in

26. *See, e.g.,* Perlin, *supra* note 1, at 11.
27. 422 U.S. 563, 576 (1975).
28. *Id.* at 565–66 & n.2.
29. *See id.* at 565–66; *see also* 42 U.S.C. § 1983 (2006).
30. *O'Connor*, 422 U.S. at 576.
31. *See id.*
32. *See id.* at 575.
33. *See id.* at 573–74.

later cases, the Court did elaborate on the grounds upon which States might predicate commitment. As implied by the justifications listed above, confinement generally rests on the police and/or parens patriae powers.[34] The police power generally justifies confinement to protect others from the individual,[35] while the parens patriae power justifies confinement for the protection of the individual from himself (or from his own inability to survive without state intervention).[36] Although the Court noted that these two powers are distinct and entail different due process limitations,[37] it did not identify how those different limitations might affect the State's power to confine.[38] State civil commitment statutes, amended to comply with *O'Connor*'s "dangerousness" requirement, do not distinguish between the two justifications, and generally apply to anyone determined to be "dangerous to self or others."[39]

34. *See id.* at 582–83 (Burger, J., concurring) ("[T]he States are vested with the historic parens patriae power, including the duty to protect 'persons under legal disabilities to act for themselves' . . . [t]he classic example of his role is when a State undertakes to act as 'the general guardian of all infants, idiots, and lunatics.'" (citing Hawaii v. Standard Oil Co., 405 U.S. 251, 257 (1972))); *see also id.* at 575 (majority opinion).

35. *See id.* at 582–83 ("There can be little doubt that in the exercise of its police power a State may confine individuals solely to protect society from the dangers of significant antisocial acts or communicable disease."); *see also* Foucha v. Louisiana, 504 U.S. 71, 80 (1992).

36. *See O'Connor*, 422 U.S. at 583 (Burger, J., concurring). New York State explicitly announces its parens patriae power over the mentally disabled in its constitution. *See* N.Y. CONST. art. XVII, § 4; *see also* N.Y. MENTAL HYG. LAW § 7.01 (McKinney 2011); *id.* § 9.47 (stating that it is the duty of local officers to see that "all mentally ill persons within their respective communities who are in need of care and treatment at a hospital" receive such treatment); *id.* § 9.21(a) (standing for the proposition that it is "the duty of all state and local officers having duties to perform relating to the mentally ill to encourage any person suitable therefor and in need of care and treatment for mental illness to apply for admission as a voluntary or informal patient").

37. *See O'Connor,* 422 U.S. at 583 (Burger, J., concurring) ("[T]he use of alternative forms of protection may be motivated by different considerations, and the justifications for one may not be invoked to rationalize another.").

38. The Court did, however, identify certain specific limitations on states' parens patriae power. *See id.* at 575 (majority opinion) ("[W]hile the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends."); *id.* at 583 (Burger, J., concurring) ("At a minimum, a particular scheme for protection of the mentally ill must rest upon a legislative determination that it is compatible with the best interests of the affected class and that its members are unable to act for themselves.").

39. *See, e.g.*, N.Y. MENTAL HYG. LAW §§ 9.37, 9.39 (McKinney 2011). New York's standards of dangerousness are compared with those of other states' in Part II, *infra*.

Significantly, Justice Burger's concurrence also recognized the difficulty involved in both defining "mental illness" and diagnosing individuals as "dangerous."[40] How these terms are defined is obviously vital to giving *O'Connor*'s holding meaning, but because both issues had been resolved by the jury below, the *O'Connor* court did not address them further.[41]

The second major distinction underlying the constitutional framework for civil commitment is the one between the liberty interests of mentally disabled individuals and the interests of society at large.[42] In a civil commitment hearing, these interests must be balanced by allocating the risk of an erroneous commitment between the individual and the State.[43] In *Addington*, a woman committed her son, a man with a history of "mental and emotional difficulties," after he had an "assaultive episode" and damaged property.[44] Challenging his commitment before a jury, Addington conceded that he suffered from mental illness but claimed that the State had not presented sufficient evidence to establish that he was dangerous.[45] The court instructed the jury that Addington could be committed if the medical testimony constituted "clear and convincing evidence" that he required hospitalization, and the jury found that this burden had been met.[46] On appeal, the Supreme Court rejected Addington's argument that the "clear and convincing" standard of proof inadequately protected him from the risk of an erroneous finding of dangerousness.[47] In so doing, the Court distinguished the interests at play in criminal proceedings, which require the state to establish proof beyond a reasonable doubt, from those in civil commitments.[48]

40. *See* 422 U.S. at 584 & n.6 (Burger, J., concurring) (citing Thomas Szasz, *The Right to Health*, 57 GEO. L.J. 734 (1969)).

41. *Id.* at 573–74.

42. *See* Addington v. Texas, 441 U.S. 418, 425 (1979) ("In considering what standard should govern in a civil commitment proceeding, we must assess both the extent of the individual's interest in not being involuntarily confined indefinitely and the state's interest in committing the emotionally disturbed under a particular standard of proof.").

43. *Id.* at 423.

44. *Id.* at 420–21.

45. *Id.* The State called two physicians, each of whom expressed the opinion that Addington suffered from "psychotic schizophrenia" with "paranoid tendencies," was "probably dangerous to himself and to others," and required "hospitalization in a closed area." *Id.*

46. *See id.*

47. *Id.* at 432–33.

48. *Id.* at 423.

The standard of proof represents not only the value that society places on an individual's liberty,[49] but also the weight of the state's interest in confinement. By applying the "clear and convincing" standard of proof, the Court simultaneously held that the interest that a nondangerous mentally disabled individual has in remaining free from unnecessary restraint is weaker than that of an innocent individual accused of a crime,[50] and that the state's interest in confining the mentally disabled is qualitatively different from its interest in confining criminals.[51]

*O'Connor* and *Addington* establish the two basic axes. Mentally ill individuals cannot be confined unless they reach a certain threshold of dangerousness, achieved either by posing a sufficient threat to society to justify the exercise of state police power or by being sufficiently incapable of caring for themselves to justify an exercise of state parens patriae power.[52] The sufficiency of that showing of

49. *Id.* at 425.

50. *See id.* at 428–29. This conclusion is premised on the assumption that the mentally disabled, unlike the wrongly convicted, stand to gain from their confinement. *See id.* at 430 (observing that the difficulty in predicting dangerousness "beyond a reasonable doubt" could force fact finders to "reject commitment for many patients desperately in need of institutionalized psychiatric care" and that "[s]uch 'freedom' for a mentally ill person would be purchased at a high price"). The court also assumes that "the layers of professional review and observation of the patient's condition, and the concern of family and friends generally will provide continuous opportunities for an erroneous commitment to be corrected." *Id.* at 428–29. This observation ignores the possibility that "professional review" may be tainted by treatment bias. *See infra* Part II.B.2. It also overlooks the fact that it was Addington's own mother who had him committed.

51. *See id.* at 428 ("In a civil commitment [as opposed to a criminal proceeding] state power is not exercised in a punitive sense."). Comparative benevolence thus grants the state broader license to confine.

52. *See* O'Connor v. Donaldson, 422 U.S. 563, 576 (1975). The Court later clarified that *O'Connor* and *Addington* established mental illness and danger as separate prerequisites to civil confinement, both of which must be established by clear and convincing evidence. *See* Foucha v. Louisiana, 504 U.S. 71, 75–76, 86 (1992) (holding that due process does not allow an individual with an "antisocial personality," who has been adjudged dangerous, to be involuntarily committed absent a showing of some treatable mental illness). A "sane" person who has not committed a crime is thus ineligible for civil confinement regardless of how predictably dangerous he or she may be. *See id. But see* Kansas v. Hendricks, 521 U.S. 346, 358–60 (1997) (permitting commitment on a finding of dangerousness coupled with an untreatable "mental abnormality"). Although *Hendricks* initially seems to abrogate the two-step *Foucha* standard, both the majority and dissent point out that Kansas' definition of "abnormality" falls within the permissible range of definitions of "mental illness" for substantive due process purposes, which must only pertain to an individual's ability to control his "dangerous" behavior. *See id.* at 359 (majority opinion); *id.* at 373–74 (Breyer, J., dissenting); *see also* Kansas v. Crane,

dangerousness is determined by balancing the state's interest in confining the genuinely dangerous against the liberty interest of individuals who may be confined erroneously. To some extent, this balance allocates the risk of over-commitment to the mentally disabled population.[53]

*O'Connor* and *Addington* intersect at the concept of "dangerousness."[54] Under this standard, a commitment is legitimate if a fact finder (either a physician certifying an initial commitment or a judge or jury at a recommitment hearing)[55] can conclude that there is clear and convincing evidence that the committed individual is dangerous. Legislatures authorizing civil commitment through statutes like Article 9 must work within those bounds, but their contours remain vague.[56] What, for example, makes a person

534 U.S. 407, 411 (2002) (clarifying that *Kansas v. Hendricks* requires a showing of some, but not "total," lack of control to establish "mental illness" for civil confinement purposes). *But see* Brian J. Pollock, Note, Kansas v. Hendricks*: A Workable Standard for "Mental Illness" or a Push Down the Slippery Slope Toward State Abuse of Civil Commitment?*, 40 ARIZ. L. REV. 319, 321–22 & n.17 (1998) (arguing that the Court's increased deference to legislatures' definition of "mental illness" detaches civil commitment "from the medical model of illness and bona fide treatment" and could lead to abuse of states' confinement powers (quoting John Q. La Fond, *Washington's Sexually Violent Predator Law: A Deliberate Misuse of the Theraputic State for Social Control*, 15 U. PUGET SOUND L. REV. 655, 698–99 (1992))).

53. *See Addington*, 441 U.S. at 427. The Court has recognized that erroneously confined individuals suffer not only from arbitrary confinement, but also from stigma and a variety of other adverse consequences. *See id.* at 425–26; *see also* Vitek v. Jones, 445 U.S. 480, 494 (1980) ("[T]he stigmatizing consequences of a transfer to a mental hospital for involuntary psychiatric treatment, coupled with the subjection of the prisoner to mandatory behavior modification as a treatment for mental illness, constitute the kind of deprivations of liberty that requires procedural protections."). These "deprivations of liberty" are described with specificity in Part I.B *infra*.

54. Justice Brennan summarized the complex balancing of interests embodied in this concept in *Jones v. United States*:

> The core of both cases [*O'Connor* and *Addington*] is a balance of three factors: the governmental interest in isolating and treating those who may be mentally ill and dangerous; the difficulty of proving or disproving mental illness and dangerousness in court; and the massive intrusion on individual liberty that involuntary psychiatric hospitalization entails.

463 U.S. 354, 372 (1983) (Brennan, J., dissenting).

55. *See infra* Part I.A.2.

56. *See Addington*, 441 U.S. at 431 ("The essence of federalism is that states must be free to develop a variety of solutions to problems and not be forced into a common, uniform mold. As the substantive standards for civil commitment may vary from state to state, procedures must be allowed to vary so long as they meet the constitutional minimum."); *see also* La Fond, *supra* note 52 (describing the dangers of leaving excessive discretion to legislatures to define the terms of confinement). *But see* Powell v. Texas, 392 U.S. 514, 536-37 (1968) (noting, with regard to a state

"dangerous" within the standard's definition? Clear and convincing evidence of "dangerousness" is required under *Addington*, but can a psychiatric prognosis alone be "clear and convincing"? As Part III of this Note will demonstrate, each state's civil commitment statute resolves these questions differently.

### *2. Procedural Limits*—Vitek v. Jones.

In *Vitek v. Jones*,[57] the Court established the minimum procedural protections required for involuntary commitment, without further clarifying the substantive *O'Connor* dangerousness standard. *Vitek* dealt with a prisoner[58] convicted of robbery who, one year into a three-to-nine year sentence, had been transferred without notice or hearing to an inpatient mental facility to be committed until no longer dangerous.[59] The Court held that despite requiring a finding of dangerousness (by a prison psychiatrist), the Nebraska statute imposed "the kind of deprivations of liberty that require[d] procedural protections."[60] Specifically, due process requires: (1) notice; (2) a hearing with the opportunity to rebut evidence relied on for the transfer; (3) the ability to present and cross-examine witnesses; (4) the ability to appear before an independent decision-maker; (5) a written statement by the fact-finder as to the evidence relied on for transfer; and (6) effective and timely notice of all the

insanity defense standard, that "[n]othing could be less fruitful than for this Court to be impelled into defining some sort of insanity test in constitutional terms . . . . It is simply not yet the time to write the Constitutional formulas cast in terms whose meaning . . . is not yet clear either to doctors or to lawyers.").

57. 445 U.S. 480 (1980).

58. While this case, like *Jackson v. Indiana*, dealt with the commitment of a convicted prisoner, the Court pointed out that involuntary commitment represents a "massive curtailment of liberty" that is qualitatively different from incarceration. *Id.* at 491 (citing Humphrey v. Cady, 405 U.S. 504, 509 (1972)); *cf.* Youngberg v. Romeo, 457 U.S. 307, 321–22 (1982) ("Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish."). Because being classified as mentally ill entails stigmatization and compulsory behavior modification treatment, neither prisoners nor ordinary citizens can be committed without the due process protections the *Vitek* Court went on to define. *See Vitek*, 445 U.S. at 493; *see also* Rodriguez v. City of New York, 72 F.3d 1051, 1061 (2d Cir. 1995).

59. *See Vitek*, 445 U.S. at 484. Vitek was found to be "suffering from a mental illness" by prison psychiatrists after setting fire to his mattress while in solitary confinement. *Id.*

60. *Id.* at 494.

foregoing rights.[61] A plurality of Justices also found that independent, state-funded counsel must be provided for indigent committees.[62]

The *Vitek* Court reiterated the underlying balance of interests between patient and state and acknowledged that the procedural protections it adopted were necessary to safeguard against the risk of being "arbitrarily classified as mentally ill and subjected to unwelcome treatment."[63] Significantly, the Court highlighted the importance of independent fact-finders and adversary hearings in what could be seen as an "essentially medical" inquiry into mental illness.[64] Qualifying the *Addington* Court's observation that diagnoses of mental illness "turn[] on the meaning of the facts which must be interpreted by expert psychiatrists and psychologists,"[65] the majority held that "[i]t is precisely '[t]he subtleties and nuances of psychiatric diagnoses' that justify the requirement of adversary hearings" with independent decision-makers.[66] In a case where a jury had not already made an assessment of dangerousness—unlike in *O'Connor* or *Addington*—the Court was moved to observe that due process cannot be satisfied where all fact-finding is left to unconstrained medical discretion.[67]

61. *See id.* at 494–96.

62. *See id.* at 496–97. The plurality, led by Justice White, found that indigent prisoners thought to be suffering from "mental disease or defect" were likely to be unable to understand or exercise their rights, making state-funded counsel appropriate. *Id.* Justice Powell agreed that appointed assistance should be provided at pre-transfer hearings, but that due process did not require that assistance to come from "a licensed attorney." *See id.* at 499 (Powell, J., concurring).

63. *Id.* at 495 (majority opinion).

64. *See id.*

65. Addington v. Texas, 441 U.S. 418, 429 (1979) (emphasis omitted).

66. *Vitek*, 445 U.S. at 495 (quoting *Addington*, 441 U.S. at 430).

67. *But cf.* Youngberg v. Romeo, 457 U.S. 307, 323 (1982) (holding that "treatment decisions" made by medical professionals are "presumptively valid," and should only be "second-guessed" by judges and juries if they are "a substantial departure from accepted professional judgment"); *see also* Bell v. Wolfish, 441 U.S. 520, 544 (1979) ("[Courts] should not 'second-guess the expert administrators on matters on which they are better informed.'" (quoting Wolfish v. Levi, 573 F.2d 118, 124 (2d Cir 1978))). The *Youngberg* case dealt with the "post-commitment" liberty interests of institutionalized individuals, and its presumption of validity was not discussed in the context of a commitment decision or dangerousness finding. *See Youngberg*, 457 U.S. at 324; *see also* Susan Stefan, *Leaving Civil Rights to the "Experts": From Deference to Abdication Under the Professional Judgment Standard*, 102 YALE L.J. 639, 667–69 (1992) (distinguishing between the pre-commitment "negative right" to be free from constraint and *Youngberg*'s "positive right" to treatment in a psychiatric institution, and determining that professional judgment is only relevant when establishing whether the latter has been adequately protected).

Since *Vitek,* the Court has not significantly revisited the substantive or procedural limitations on involuntary commitment. Although the extent to which states can define "dangerousness" has been litigated frequently since the early 1980s, the Court's minor modifications to the *O'Connor* standard in *Foucha v. Louisiana*[68] and *Kansas v. Hendricks*[69] provide little additional guidance.[70] In its most recent opinion dealing with civil commitment—interpreting a federal sex offender commitment statute—the Court explicitly left the states' "leeway" untouched.[71]

Each state legislature, including New York's, has dealt differently with "dangerousness" and the minimum procedural requirements for civil commitment.[72] Having identified the intentionally indistinct constitutional framework on which it rests, the next section will examine Article 9 itself. A provision-by-provision breakdown will help reveal the extent to which the state legislature has used

68. *See* 504 U.S. 71 (1992).

69. *See* 521 U.S. 346 (1997); *see also* Kansas v. Crane, 534 U.S. 407 (2002) (clarifying *Hendricks*).

70. *See, e.g.*, *Crane*, 534 U.S. at 413 ("[T]he Constitution's safeguards of human liberty in the area of mental illness and the law are not always best enforced through precise bright-line rules. For one thing, the States retain considerable leeway in defining the mental abnormalities and personality disorders that make an individual eligible for commitment.").

71. *See* United States v. Comstock, 130 S. Ct. 1949, 1956 (2010) ("In resolving that question [whether a statute authorizing commitment of individuals who (1) have engaged or attempted to engage in sexually violent conduct, (2) currently suffer from a serious mental illness, abnormality, or disorder, and (3) are sexually dangerous to others], we assume, but we do not decide, that other provisions of the Constitution—such as the Due Process Clause—do not prohibit civil commitment in these circumstances. In other words, we assume for argument's sake that the Federal Constitution would permit a State to enact this statute . . . ." (citing *Addington,* 441 U.S. 418 (1979))). This language is particularly significant in light of the district court's ruling that the showing of a past act or attempt of sexually violent conduct must be made beyond a reasonable doubt, rather than by clear and convincing evidence, given that the proceeding could result in "the taking of an individual's liberty." *See* United States v. Comstock, 507 F. Supp. 2d 522, 552 (E.D.N.C. 2007), *aff'd*, 551 F.3d 274 (4th Cir. 2009), *rev'd on other grounds*, 130 S. Ct. 1949 (2010). The Supreme Court overturned the District Court on other grounds, declining an opportunity to overrule *Addington*. *See Comstock*, 130 S. Ct. at 1956; *see also* Alex Tsesis, *Due Process in Civil Commitments*, 68 WASH. & LEE L. REV. 253, 254–55 (2011) (lamenting that the *Comstock* Court missed an opportunity to reevaluate *Addington* in light of recent studies casting doubt on psychiatrists' ability to make accurate predictions of dangerousness).

72. *See, e.g.*, N.Y. MENTAL HYG. LAW § 9.01 (McKinney 2011) (defining "likelihood to result in serious harm" to self or others for the purposes of Article 9 commitments).

commitment standards to allocate the risk of erroneous commitment to New York's mentally disabled population.

## B. How Article 9 Works

There are, in general, three ways to be committed to an inpatient mental institution under New York law: voluntarily,[73] involuntarily,[74] and through emergency commitment.[75] Each entails a different set of procedures, forms, and minimum and maximum periods of confinement.[76] The legal status under which a person is committed is recorded in his or her medical record[77] and determines the type of program in which he or she can receive treatment.[78] A committee's status may change during his hospitalization, but any change in status entails its own set of assessments and procedures.[79] This Part will deal with each statutory status separately.

### *1. Voluntary Commitment*

Voluntary commitment can happen either informally[80] or by application.[81] Informal voluntary commitment is not terribly intrusive, requiring no written application and leaving the patient "free to leave . . . at any time."[82] Informal committees do not have

73. *See id.* §§ 9.13, 9.15.

74. *See id.* §§ 9.27, 9.37.

75. *See id.* §§ 9.39, 9.40.

76. A helpful chart laying out these different admission procedures can be found on the New York State Office of Mental Health's (OMH) website, *available at* http://www.omh.ny.gov/omhweb/forensic/manual/html/mhl_admissions.htm (last visited Feb. 25, 2013).

77. N.Y. MENTAL HYG. LAW § 9.03 (McKinney 2011); *see also id.* § 9.11 (requiring patients' records to be forwarded to Mental Hygiene Legal Service (MHLS)); *id.* § 33.13 (defining the required contents of a patient's file, including any treatments and any restrictions on patient's rights, and setting confidentiality requirements).

78. *See, e.g.*, *id.* § 9.40 (special procedure for admission to a Comprehensive Psychiatric Emergency Program (CPEP)).

79. *See, e.g.*, *id.* § 9.07 (requiring notice to patients of the statutory rights provided under each admission status); *id.* § 9.09 (requiring notice to MHLS within three days of any patient's change of status or transfer to a different facility).

80. *See id.* § 9.15.

81. *See id.* § 9.13.

82. *See id.* § 9.15; *see also* Paradies v. Benedictine Hosp., 431 N.Y.S.2d 175 (App. Div. 3d Dep't 1980) (finding, in wrongful death action by wife of a patient committed under § 9.15, that doctors were not liable because they had no right to retain him after he demanded release).

their records forwarded to the Mental Hygiene Legal Service[83] ("MHLS") and need not satisfy any dangerousness standard.[84] After requesting to be informally admitted, a prospective committee must be given notice (1) that the hospital to which he is requesting admission is a hospital for the mentally ill, (2) that he is applying for admission, and (3) of the possibility of and conditions for being converted to involuntary status.[85] Any physician in the department can then examine the prospective committee to determine whether he meets the informal admission standard.[86] At this juncture, the examining physician may commence procedures to have the person applying for informal admission committed pursuant to another, stricter section of Article 9—anything from voluntary to emergency commitment.[87] Every twelve months following informal commitment, informal and voluntary committees must be reassessed to determine whether they continue to be in need of care and treatment and are willing to remain confined; this determination must be communicated to MHLS, which may request a hearing to challenge it.[88] Once every 120 days of hospitalization, the director must re-inform all voluntary and informal patients of their status and rights, at which time the patient must give written consent to continued hospitalization.[89] These patients are thus reappraised of their rights and given the opportunity to object to their commitment at least three times per year.

Voluntary committees must meet the same "need for care and treatment" standard as informal committees but must make written application to the hospital director for voluntary status.[90] The parent or guardian of a person under the age of eighteen can submit this application to request "voluntary" admission on the minor's behalf.[91]

83. *See* N.Y. MENTAL HYG. LAW § 9.11.

84. *See id.* § 9.15 ("The director . . . may receive therein as an informal patient any suitable person in need of care and treatment requesting admission thereto."). Section 9.01 defines "in need of care and treatment" as having a mental illness "for which in-patient . . . treatment is appropriate." *Id.* § 9.01.

85. *See id.* § 9.17(a).

86. *See id.* § 9.17(b).

87. *See id.*

88. *See id.* § 9.25(a).

89. *See id.* § 9.19.

90. *Id.* § 9.13(a).

91. *Id.; see also* Samuel M. Leaf, *How Voluntary Is the Voluntary Commitment of Minors? Disparities in the Treatment of Children and Adults Under New York's Civil Commitment Law*, 62 BROOK. L. REV. 1687, 1716–17 (1996) (arguing that

A voluntary patient is subject to many of the same procedural requirements as an informal patient, including entitlement to notice of possible conversion to involuntary status[92] and annual reevaluation for suitability and willingness.[93] Additionally, a voluntary patient's medical records, including treatment information specified by Section 33.13, must be forwarded to MHLS within five days of admission.[94] This increased oversight is presumably in place because voluntary patients, unlike informal patients, are not free to leave the hospital at will, but must submit written notice of their "desire to leave."[95] The hospital director may then retain the patient for up to seventy-two hours to apply for an order for retention, which the patient may contest at a hearing set within three days of the director's application.[96] If the hearing court finds that the patient is "in need of retention for involuntary care," a sixty-day retention order issues, and the patient's status is converted to involuntary.[97]

### *2. Involuntary Commitment*

Involuntary status can come about through a retention order and change of status following the director's refusal to discharge a voluntary patient, through an emergency commitment for immediate observation,[98] or through a non-emergency involuntary commitment.[99] Any of eleven enumerated parties,[100] including a family member, treating psychiatrist, or person residing with the prospective committee can apply to a hospital to initiate a non-emergency involuntary commitment.[101] Within ten days of this application, two physicians must examine the committee and certify that he or she is

Sections 9.13 and 9.27 leave enormous power to parents to unnecessarily commit their children).

92. *Id.* § 9.17(a).

93. *Id.* § 9.25(a).

94. *Id.* § 9.11.

95. *Id.* § 9.13(b).

96. *Id.* This hearing is not automatic; if the patient does not request it within five days of the application, a six-month retention order may be issued uncontested. *See id.* § 9.33(b).

97. *Id.* This order must be issued pursuant to the procedure for retaining an involuntary committee provided in § 9.33(a), described in Part I.B.4 *infra*.

98. *See infra* Part I.B.3.

99. *See* N.Y. MENTAL HYG. LAW § 9.27(a).

100. *Id.* § 9.27(b).

101. *Id.* § 9.27(a); *see also* § 9.27(c) (application must contain statement of facts upon which allegation of mental illness and need for care and treatment are based, and is executed under penalty of perjury).

mentally ill and "in need of *involuntary* care and treatment."[102] This standard (the "involuntary standard"), while higher than the "care and treatment" standard for voluntary commitment,[103] does not explicitly require a finding of dangerousness.[104] Before certifying the need for involuntary treatment, both examining physicians are under a statutory duty to "consider" less restrictive alternatives and, if possible, to consult with any psychiatrist who has previously treated the potential committee.[105] After certification of the application, either examining physician can direct police officers to transport the potential committee to the hospital for further evaluation, and may request ambulance service for this purpose.[106] Before final admission to the hospital, a third physician must examine the potential committee to confirm that he or she meets the involuntary standard.[107] After final admission, the committee can be held for a maximum of sixty days, at which time the hospital must either grant discharge or apply for a retention order.[108] Written notice of involuntary admission must be given "forthwith" to MHLS and to the committee's nearest known relative.[109]

Two aspects of the non-emergency involuntary commitment procedure warrant particular mention. First, at no point during the commitment process—application, certification, and admission—is a judge or non-physician fact-finder involved. A psychiatrist can make the application, two more psychiatrists can certify it, and a fourth can

102. *Id.* § 9.27(a) (emphasis added). This examination can be conducted "jointly" by both certifying physicians. *Id.*

103. *Cf. supra* note 88 and accompanying text.

104. The statute defines the involuntary care and treatment standard as requiring that the patient "has a mental illness for which care and treatment as a patient in a mental hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment." *Id.* § 9.01. In order to square this standard with *O'Connor*, New York courts have read dangerousness into the statute. *See, e.g.*, N.Y.C. Health & Hosps. Corp. v. Brian H., 857 N.Y.S.2d 530, 533 (App. Div. 1st Dep't 2008); *In re* Harry M., 468 N.Y.S.2d 359, 364–65 (App. Div. 2d Dep't 1983); Scopes v. Shah, 398 N.Y.S.2d 911, 913 (App. Div. 3d Dep't 1977); *see also* Project Release v. Prevost, 722 F.2d 960, 973 (2d Cir. 1983) (finding that Section 9.27, as narrowed by New York state courts, withstood a due process overbreadth challenge).

105. *See* N.Y. MENTAL HYG. LAW § 9.27(d).

106. *See id.* § 9.27(i).

107. *See id.* § 9.27(e).

108. *See id.* § 9.33(a). Involuntary committees can also be converted to voluntary status at the hospital's discretion, § 9.23(a), provided that MHLS is notified of the conversion. Any committee so converted may challenge the conversion at a hearing. *See* § 9.23(b).

109. *See id.* § 9.29.

confirm admission, before the committee has a chance to request judicial intervention. Second, although state courts have read a "substantial threat of harm to self or others" element into the statutory "involuntary commitment" standard, the plain language of Article 9 does not require one. Neither the statute nor the courts specify the severity or imminence of the harm that needs to be threatened, or whether the threat needs to be manifested by any objective evidence beyond a psychiatric prognosis.[110]

### *3. Emergency Commitment*

In addition to standard voluntary and involuntary commitments, Article 9 permits emergency admission for "immediate observation, care, and treatment"[111] in either an ordinary psychiatric facility[112] or a CPEP.[113] Emergency commitments do not require an application, and can be effected by any psychiatrist in an OMH-licensed facility,[114] or any hospital director,[115] police officer,[116] mobile crisis outreach team,[117] or through a civil court order,[118] upon a finding that an individual

110. *See, e.g.*, Scopes v. Shah, 398 N.Y.S.2d 911, 913 (App. Div. 3d Dep't 1977) (expressly disclaiming the need for an "overt act" to establish the threat of harm).

111. *See* N.Y. MENTAL HYG. LAW § 9.39. Emergency commitments also can be effected by application of a director or his designee, using the emergency standard. *See id.* § 9.37(a). In counties with fewer than 200,000 residents, this designee may be either a physician or a certified social worker. *See id.* § 9.37(c).

112. A facility must receive special certification from the OMH to receive emergency or CPEP committees. *See id.* §§ 9.39(a), 9.40(a). There are currently nineteen hospitals in New York State certified by OMH to receive CPEP committees under § 9.40, ten of which, including Bellevue, are in New York City. *See* N.Y. STATE OFFICE OF MENTAL HEALTH, REPORT TO THE GOVERNOR AND LEGISLATURE PURSUANT TO ARTICLE 10 OF NEW YORK STATE MENTAL HYGIENE LAW (2008), *available at* http://www.omh.ny.gov/omhweb/statistics/forensic/report.pdf.

113. *See* N.Y. MENTAL HYG. LAW § 9.40(a).

114. *See id.* § 9.55.

115. *See id.* § 9.57.

116. *See id.* § 9.41. Police officers who determine that a person is suffering from mental illness "likely to result in serious harm" to self or others are authorized to detain and transport such person pending psychiatric examination. *See id.*; *see also* Disability Advocates, Inc. v. McMahon, 279 F. Supp. 2d 158, 168–69 (N.D.N.Y. 2003), *aff'd*, 124 F. App'x 674 (2d Cir. 2005) (holding that Section 9.41 police "pick ups" are functionally arrests, requiring *Miranda* warnings and allowing criminal background checks).

117. *See* N.Y. MENTAL HYG. LAW § 9.58(a).

118. *See id.* § 9.43.

meets a heightened "emergency" standard of dangerousness.[119] Within forty-eight hours of initial admission[120] a second physician must examine the committee and confirm that the emergency standard is satisfied.[121] After confirmation, the committee may be retained for up to fifteen days, at which point he must be either discharged or converted to non-emergency involuntary status through the standard involuntary procedure.[122] At any time following confirmation, the committee, any friend or relative, or MHLS may demand a hearing, which must be granted within five days.[123] If the hearing court finds that the emergency standard is met, it may issue a retention order for the remainder of the fifteen-day commitment—this order is considered a finding of "reasonable cause" but not an adjudication that the committee is mentally ill.[124]

Admission to a CPEP functions similarly to standard emergency commitment in that it uses the same standard[125] and the same range of authorized actors initiate the admission, but it differs from emergency commitment in that a prospective committee may be held for observation for up to six hours before a psychiatrist examines him.[126] If the initial psychiatrist deems that commitment to a CPEP is appropriate, the committee may be held for up to twenty-four hours before confirmation by another psychiatrist and transfer to an

119. *See id.* § 9.39(a). The emergency standard requires a finding that the prospective committee (1) suffers from a mental illness that is (2) likely to result in serious harm to himself or others. *See id.* "Likelihood of serious harm" is defined as

> (1) a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself, or (2) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

*Id.* § 9.01.

120. As in a non-emergency involuntary commitment, notice of rights and status must be given to the committee, MHLS, and the committee's next relative immediately upon admission. *Id.* § 9.39(a).

121. *See id.*

122. *See id.* § 9.39(b). Standard Section 9.27 procedure is described in Part I.B.2 *supra*. If a patient is converted from emergency to involuntary status, their date of admission for the purposes of the sixty-day involuntary admission period is calculated from the date of initial admission, rather than conversion. *Id.* § 9.39(b).

123. *See id.*

124. *See id.*

125. *See id.* § 9.40(b). The "likelihood of serious harm" requirement is the same, but the physician must conclude that the committee is in particular need of CPEP, rather than standard emergency admission. *Id.*

126. *See id.*

extended observation bed.[127] The maximum "extended observation" period in a CPEP is seventy-two hours, after which time the committee must be discharged or converted to standard emergency[128] or non-emergency involuntary status.[129]

The emergency standard is the highest threshold of dangerousness required under Article 9.[130] It differs from the lower involuntary standard in three important respects. First, it explicitly specifies the need for a finding of harm to self or others, tracking the *O'Connor* standard.[131] Second, it specifies the severity of the threat, although it does not specify imminence. Third, it requires the threat to be manifested by some objective, overt act by the prospective committee, either in the form of a threat or attempt at suicide or violent behavior. This requirement reduces the discretion of physicians to diagnose dangerousness by resting the legitimacy of an emergency commitment on factual evidence. The need for a more objective standard is clear, given that such a broad range of actors can initiate a commitment, and the allegedly dangerous person can be initially committed for up to forty-eight hours on the assessment of a single physician.[132]

### *4. Retention Orders, Release Hearings, and Other Procedural Protections*

New York law affords minimal procedural protections[133] to all voluntarily and involuntarily committed patients by providing notice of status and rights,[134] opportunities for hearings to present and rebut evidence, and opportunities for judicial review of all commitment

127. *See id.* § 9.40(c). On transfer to an extended observation bed, notice and possibility of hearing must be given to the committee under the same procedure as Section 9.39. *See also id.* § 31.27(5) (defining "extended observation bed" as an inpatient bed in or adjacent to an emergency room where the committee's "acute psychiatric symptoms" can be stabilized).

128. *Id.* § 9.40(a), (e).

129. *Id.* § 9.40(f).

130. *Compare id.* § 9.13(a) ("need for care and treatment"), *with id.* § 9.27(a) ("need for involuntary care and treatment"), *and id.* § 9.39(a) ("likely to result in serious harm").

131. *See* O'Connor v. Donaldson, 422 U.S. 563, 576 (1975).

132. N.Y. MENTAL HYG. LAW § 9.39(a).

133. See *Vitek v. Jones*, 445 U.S. 480, 494–97 (1980), discussed *supra* in Part I.B.2.

134. *See* N.Y. MENTAL HYG. LAW § 9.07(a) (requiring notice of status and rights to hearing and counsel immediately upon admission or status conversion); *id.* § 9.07(b) (requiring notices of rights to be posted conspicuously throughout the facility in locations visible to all patients).

decisions,[135] and goes beyond the constitutional minimum by providing state-funded counsel to indigent committees through MHLS.[136] Within the initial sixty-day period of an involuntary commitment, no automatic hearing is triggered; however, a committee, their next relative, or MHLS can request one at any time after receiving notice of involuntary status.[137] No involuntary commitment can continue beyond the initial sixty-day period without a court order of retention.[138] Initial orders of retention can be for up to six months,[139] subsequent orders may be for one year, then two years at a time.[140] Provided the hearing court finds that the committee continues to meet the involuntary standard, two-year retention orders may continue to be granted indefinitely.[141]

If a hearing is requested by or on behalf of a committee, it must be scheduled within five days.[142] The committee, represented by MHLS or his own counsel, may present evidence to contest the validity of his involuntary status and cross-examine the hospital's witness, usually a psychiatrist.[143] If after hearing this evidence the court is satisfied that retention is appropriate, it may deny release and may order transfer to another facility; if not, it must order release.[144] The court is also obliged to consider whether the committee has relatives willing and able to provide appropriate care, in which case it may order release

135. *See id.* § 9.31 (right to hearing regarding involuntary commitment status, requiring court to hear testimony); *id.* § 9.35 (right to review of order authorizing retention by another court, and appeal that court's decision).

136. *See, e.g.*, *id.* § 43.01(a) (waiving fees for patients unable to pay for services); *id.* § 15.1 (requiring, as part of the admission process, an assessment of "those social and economic factors which will impede and those which will facilitate a patient's discharge"); *see also id.* § 47.01 (establishing the responsibilities of MHLS to provide legal services to all "patients or residents" of a mental facility or "persons alleged to be in need of care and treatment"); *id.* § 9.09 (requiring notice to MHLS within three days of any admission of a new patient or change of a patient's status); *id.* § 9.11 (requiring records of all involuntary patients to be forwarded to MHLS).

137. *Id.* § 9.31(a).

138. *Id.* § 9.33(a).

139. *See id.* § 9.33(b).

140. *See id.* § 9.33(d).

141. *See id.*

142. *See id.* § 9.31(c).

143. *See id.*

144. *See id.* The facility need not release the patient immediately but must release them "forthwith." *See id.* § 9.31(d).

into their custody.[145] A committee denied release may be retained under involuntary status for the remainder of his term.[146]

Both retention orders and denials of release can be reviewed.[147] Request of review must be made within thirty days, and may only be made by the committee or an immediate family member.[148] The review procedure is much more robust than the standard release hearing, calling for both a supreme court justice (other than the judge or justice who issued the order) and a jury[149] to try the questions of (1) mental illness and (2) need for involuntary retention.[150] If the jury finds that both of these factual elements are shown by clear and convincing evidence,[151] the committee is adjudged mentally ill and an order is issued to the hospital authorizing retention for the remainder of the term.[152] The justice presiding over the review may, at his discretion and after a hearing, stay this order pending an appeal.[153]

## II. PROBLEMS WITH ARTICLE 9, AND MORE PROTECTIVE ALTERNATIVES

The preceding analysis of Article 9's procedural labyrinth reveals that New York State law provides close to the federally mandated minimum of protection against erroneous commitment. At key stages of the commitment process, the law devolves decision-making authority onto physicians and limits committees' access to lay decision-makers and judges. This Part will examine the extent to

145. *See id.* § 9.31(c).

146. *See id.* A committee may be retained for thirty days after being denied release regardless of when their initial term ends; denial therefore may result in an extended term if release is requested with fewer than thirty days remaining on the retention term. *See id.* § 9.33(a).

147. *See id.* § 9.35.

148. *See id.*

149. Jury review may be waived. *See id.*

150. *See id.*

151. This standard of proof is not referenced in Article 9 but is mandated by *Addington v. Texas*, 441 U.S. 418, 421 (1979).

152. *See id.*; N.Y. MENTAL HYG. LAW § 9.35.

153. *See* N.Y. MENTAL HYG. LAW § 9.35. Only the jury's finding of a need for treatment may be appealed; the type of treatment administered and treatment classification (admission status) may not. *See* Jamie R. v. Consilvio, 6 N.Y.3d 138, 147–48 (2006). A committee who has been adjudged mentally ill and in need of treatment by the reviewing jury may not request another review pursuant to § 9.35 during his retention term without establishing some change in legal or factual circumstances that would enable a fact finder to reconsider the previous reviewing fact finder's verdict. *See, e.g.*, *In re* Launcelot T., 668 N.Y.S.2d 431, 432 (Sup. Ct. 1997).

which New York State has chosen to allocate the risk of over-commitment onto its mentally disabled population. Section A will focus on some key deficiencies built into Article 9. Section B will survey more protective alternative civil commitment procedures that other jurisdictions have adopted, noting instances where the Second Circuit has heard challenges to Article 9 and declined to find alternative procedural protections necessary to the law's survival.

### A. Delegated Discretion—the Problem with Article 9

Article 9 incorporates the basic procedural requirements for involuntary commitment under *Vitek v. Jones* by providing notice of rights and status, allowing committees to seek judicial review of both retention orders and demands for early release, requiring notice to MHLS of all hearings and status changes, and granting MHLS significant power to request hearings on committees' behalf.[154] Facilitating adversary hearings ostensibly introduces objective, non-medical decision-makers into the commitment process. Nevertheless, even as read by state courts to include a dangerousness requirement, New York law treads close to the constitutional boundaries of involuntary commitment. Article 9 sets exceedingly broad standards for commitment, widening the population of New Yorkers who might qualify as "in need of involuntary care and treatment" and delegating enormous power to physicians, both as gatekeepers (by controlling initial admission) and as expert witnesses in hearings for retention. Because judges tend to defer to their medical expertise,[155] a psychiatrist's diagnosis can provide all the evidence necessary to satisfy the legal "dangerousness" standard. Article 9 does little to restrict this discretion; thus, to whatever extent psychiatrists tend to erroneously predict dangerousness or misdiagnose patients, New York errs on the side of over-commitment. Because only the mentally disabled are eligible for commitment, this burden falls entirely on them.

154. *See* Project Release v. Prevost, 722 F.2d 960, 975 (2d Cir. 1983) (holding that the Article 9 meets *Vitek*'s "constitutional minima" because of its "elaborate" notice and hearing provisions).

155. *See* Brooks, *supra* note 21, at 284–85 nn.138–39 (describing judges' deference to clinical testimony, citing a variety of studies showing that judges defer to psychiatric recommendations between ninety and one hundred percent of the time); *see also* William Hoffman Pincus, Note, *Civil Commitment and the "Great Confinement" Revisited: Straightjacketing Individual Rights Stifling Culture*, 36 WM. & MARY L. REV. 1769, 1806–07 (1995) (citing a similar study).

Other states have chosen to err on the side of under-commitment. In recognition of the need to provide more procedural protections—such as those under criminal law—to their disabled populations, some state legislatures have enacted stricter commitment statutes, incorporating higher burdens of proof and standards of dangerousness or requiring objective evidence, rather than mere diagnosis, to establish the need for commitment. State and federal courts have adopted similar rights-protective measures through judicial doctrines. The next section will examine these measures in comparison with New York's commitment law, starting with a foundational federal case, *Lessard v. Schmidt*.[156]

### B. More Protective Alternatives

As the Supreme Court has defined, involuntary civil commitment laws must strike two important balances, both of which allocate burdens between the State and the mentally disabled individual: first, they must set a substantive definition of "dangerousness" that determines what particular evidence must be produced to support a commitment, defining the class of "dangerous" individuals;[157] second, they must set a burden of proof, allocating the risk of an erroneous "dangerous" classification.[158] Since these broad guidelines were first enunciated in the 1970s, both the Supreme Court[159] and academic commentators[160] have consistently noted that, when striking these balances, courts and legislatures must account for the role that psychologists and clinical testimony will play in establishing mental illness and dangerousness. A vague definition of "danger to self or

156. 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1974), *reinstated and enforced*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated on other grounds*, 421 U.S. 957 (1975), *reinstated*, 413 F. Supp. 1318 (E.D. Wis. 1976).

157. *See* O'Connor v. Donaldson, 422 U.S. 563 (1975), discussed *supra* notes 27–41 and accompanying text.

158. *See* Addington v. Texas, 441 U.S. 418, 425 (1979), discussed *supra* notes 42-56 and accompanying text.

159. *See* Vitek v. Jones, 445 U.S. 480, 495–96 (1980) (recognizing that "[t]he question whether an individual is mentally ill" and requires treatment "turns on the meaning of the facts which must be interpreted by expert psychiatrists and psychologists," but that "[t]he medical nature of the inquiry . . . does not justify dispensing with due process requirements" including adversary hearings before a neutral fact-finder).

160. *See, e.g.*, Donald N. Bersoff, *Judicial Deference to Nonlegal Decisionmakers: Imposing Simplistic Solutions on Problems of Cognitive Complexity in Mental Disability Law*, 46 SMU L. REV. 329 (1992) (noting a legal tendency to delegate decisionmaking to mental health professionals).

others" or lack of a requirement that dangerousness must be established by any objective evidence (such as an overt act) may allow commitment based solely on the clinical testimony of one or two examining psychologists.[161] To cut back on that delegation of discretion, jurisdictions outside New York have implemented a variety of protective measures to shift fact-finding to judicial, rather than clinical, decision-makers.[162] These measures include (1) mandatory, rather than optional, judicial review of all non-emergency commitments; (2) elevated standards of proof; (3) more specific standards of "dangerousness," including requirements relating to likelihood, severity and imminence of potential harm; and (4) requiring objective evidence in addition to clinical opinion, such as a recent overt act, to establish dangerousness. This Part considers each in turn.

### *1. Automatic Hearings*

*Lessard v. Schmidt*,[163] one of the first cases to overturn a state's commitment statute on due process grounds, recognized that the quasi-criminal nature of involuntary commitment meant it could only be accomplished through an adversarial hearing.[164] The *Lessard* court reasoned that because the liberty interests at stake in a civil commitment are analogous to those at stake in a criminal prosecution,[165] neither could be accomplished without a prior

161. *See* Brooks, *supra* note 21, at 293 ("[I]n the absence of statutory language or a judicial opinion clarifying the meaning of 'danger,' a clinician can interpret any threat to cause harm as creating a danger, regardless of the remoteness of the threat."); *see also* Doremus v. Farrell, 407 F. Supp. 509, 516 (D. Neb. 1975) (finding that an overly vague commitment statute "combine[d] the investigative, prosecutorial, and adjudicative functions in one authority and denie[d] the subject due process of law").

162. *See* Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433, 445 (1992) (discussing the respective abilities of judicial and clinical authorities to be "neutral factfinders," and concluding that clinical authorities tend to be more prone to bias). The problem of commitment bias among psychiatric professionals is especially troubling given the demonstrated deference afforded to clinical testimony by judges. *See supra* note 153; *infra* Part II.B.4.

163. 349 F. Supp. 1078 (E.D. Wis. 1972).

164. *See id.* at 1088–89 (dismissing "the civil-criminal distinction" between deprivations of liberty).

165. *See id.* at 1089–90 (identifying loss of civil rights, hazards of institutionalization, and stigma as implicated interests). In its discussion of the consequences that could follow from even a brief erroneous commitment, the court cites testimony that "in the job market, it is better to be an ex-felon than [an] ex-

hearing.[166] Although the Court recognized that temporary emergency confinement could be necessary in some circumstances, it set a 48-hour time limit on such commitments,[167] and held categorically that commitment for any longer period "*cannot be permitted* under our Constitution without a hearing."[168] This unconditional language is understandable in the context of the analogy to criminal prosecutions; clearly, adjudication of guilt is a mandatory, not optional, prerequisite to incarceration. Although the Supreme Court in *Vitek* did not explicitly require automatic hearings prior to commitment,[169] other courts have followed *Lessard* in holding that hearings must be automatically triggered within a short time after any involuntary commitment.[170] State legislatures have imposed similar requirements by statute.[171]

Article 9 allows commitment for up to sixty days without a hearing, unless MHLS, the committee, or, in some cases, a family member requests one.[172] If a committee is unwilling or unable to request a hearing, by reason of his illness or simple mistrust of the system, and MHLS fails or does not have the resources to request a hearing on his behalf, his liberty is in the hands of the physicians until the mandatory retention hearing is triggered. This state of affairs amounts to a presumption that the committed individual has waived the right to a hearing and acquiesces to treatment until he objects. Nevertheless, when the Second Circuit addressed Article 9's hearing provisions in *Project Release*,[173] it held that the statute's lack of an automatic

patient." *See id.* at 1089 (citing *Hearings Before S. Subcomm. on Constitutional Rights*, 91st Cong. 284 (1970) (statement of Bruce J. Ennis, ACLU)).

166. *See id.* at 1091.

167. *See id.*

168. *Id.* (emphasis added).

169. *See* Vitek v. Jones, 445 U.S. 480, 495 (1980) (holding only that adversary hearings must be held sufficiently after notice to let the prospective committee prepare).

170. *See, e.g.*, Doe v. Gallinot, 486 F. Supp. 983, 994 (C.D. Cal. 1979) (seven-day limit for a probable cause hearing), *aff'd*, 657 F.2d 1017, 1025 (9th Cir. 1981); Kendall v. True, 391 F. Supp. 413, 419 (W.D. Ky. 1975) (full hearing within twenty-one days); Doremus v. Farrell, 407 F. Supp. 509, 515 (D. Neb. 1975) (finding Nebraska's civil commitment statute deficient in "failing to *require* a full and formal hearing on the necessity for commitment to be held within a reasonable time," and setting a fourteen-day limit (emphasis added)).

171. *See* Project Release v. Prevost, 722 F.2d 960, 975 n.14 (2d Cir. 1983) (citing state statutes that require prompt, automatic hearings).

172. See N.Y. MENTAL HYG. LAW § 9.31(a) (McKinney 2011), discussed *supra* in Part I.B.4.

173. 722 F.2d 960.

preliminary hearing satisfied due process.[174] This holding was based partly on a rejection of the analogy between civil and criminal confinement,[175] and partly on an optimistic assessment that the "layers of professional review" by physicians would be sufficient to screen out erroneous commitments even without automatic judicial intervention.[176] As this Note[177] will demonstrate, this assessment may place too much confidence in the ability of physicians to serve as objective fact-finders.

### *2. Elevated Standards of Proof*

*Lessard* also held that the state must prove beyond a reasonable doubt all facts necessary to show that an individual is mentally ill and dangerous.[178] The Supreme Court in *Addington* subsequently held that a clear and convincing standard could satisfy minimum due process;[179] however, at least one state elected to impose the higher standard.[180] The Court has explicitly condoned this practice as within states' discretion.[181] Some commentators have suggested that the Court should reconsider the *Addington* minimum in light of developments in diagnostic abilities;[182] regardless, it is fully within the legislative power of New York State to raise the standard and allocate

174. *See id.* at 973–74.

175. *See id.* at 974–75 ("We acknowledge the deprivation of liberty involved in involuntary civil commitment, but we are not prepared to invoke the same procedural standards required in the criminal context.").

176. *See id.* at 975 (finding that notice to relatives, combined with the *availability* of a hearing, was sufficient).

177. *See infra* Part II.B.4.

178. *See* Lessard v. Schmidt, 349 F. Supp. 1078, 1095 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1974), *reinstated and enforced*, 379 F. Supp. 1376 (D. Wis. 1974), *vacated on other grounds*, 421 U.S. 957 (1975), *reinstated*, 413 F. Supp. 1318 (E.D. Wis. 1976).

179. *See supra* notes 42-56 and accompanying text.

180. *See* KY. REV. STAT. ANN. § 202A.076(2) (West 2011); *see also* Messer v. Roney, 772 S.W.2d 648, 649–50 (Ky. Ct. App. 1989) (justifying the higher standard of proof by analogy between the loss of liberty in civil and criminal confinements).

181. *See* Heller v. Doe, 509 U.S. 312, 333 (1993) (holding that Kentucky statutes imposing a "reasonable doubt" standard for commitment of the mentally ill, but a "clear and convincing" standard for commitment of the mentally retarded, do not violate equal protection because the comparative difficulty in diagnosing mental illness, and more invasive treatment, provide a rational basis for allocating less of the risk of error to the mentally ill); *id.* at 341 n.5 (Souter, J., dissenting) ("[I]n this case Kentucky has determined that the liberty of those alleged to be mentally ill is sufficiently precious that the State should assume the risk inherent in use of that higher standard.").

182. *See* Tsesis, *supra* note 71, at 254–55.

less risk to its enormous disabled population.[183] The *Project Release* court recognized this, but reiterated its reliance on *Addington* in refusing to equate civil and criminal confinement.[184]

### *3. The Definition of "Danger"*

The *O'Connor* dangerousness standard reduced the discretion of legislatures to confine "inconvenient" individuals at will,[185] but much of that reduction may be illusory to the extent that states can define what "dangerous" means or simply shift the discretion to commit into the hands of physicians.[186] Most state civil commitment statutes provide a more specific standard than mere "danger."[187] These specifications tend to incorporate different "components of the dangerousness determination": probability, imminence, and magnitude of harm.[188] Stricter definitions of both danger and mental illness would require all three of these components to be statutorily defined—it would require, for example, a finding that danger is certain or reasonably certain, imminent, and that the resulting harm would be serious—but few states incorporate all three.[189] Article 9 provides few substantive definitions, and notably leaves "mental illness" completely undefined.[190] The emergency standard defines the

183. *See Heller*, 509 U.S. at 341 n.5 (Souter, J., dissenting) ("[I]n this case Kentucky has determined that the liberty of those alleged to be mentally ill is sufficiently precious that the State should assume the risk inherent in use of that higher standard.").

184. *See* Project Release v. Prevost, 722 F.2d 960, 974–75 (2d Cir. 1983). The Second Circuit cited the *Addington* Court's observation that, because the mentally ill may be deprived of "needed medical treatment" by an erroneous *failure* to commit, the reasonable doubt standard could create too high a barrier to the State's ability to forcibly administer that treatment. *See id.*

185. *See supra* Part I.A.1.

186. *See* Brooks, *supra* note 21, at 261–65 (arguing that, in part because of vague definitions of danger, the post-*O'Connor* "narrowing of commitment statutes failed to result in a decrease in the instances of commitment, which suggests that tighter standards and procedures have not been applied in practice").

187. *See* People v. Stevens, 761 P.2d 768, 772–73 nn.4–8 (Colo. 1988) (surveying different states' commitment standards).

188. *See* Brooks, *supra* note 21, at 265; *cf.* Christyne E. Ferris, Note, *The Search for Due Process in Civil Commitment Hearings: How Procedural Realities Have Altered Substantive Standards,* 61 VAND. L. REV. 959, 966–67 (2008) (identifying the three components as type, immediacy, and likelihood of danger).

189. *See* Ferris, *supra* note 188, at 967 (citing BRUCE J. WINICK, CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL 61–64 (2005)).

190. *See* N.Y. MENTAL HYG. LAW § 9.01 (McKinney 2011); *see also* Christopher Slobogin, *Rethinking Legally Relevant Mental Disorder*, 29 OHIO N.U. L. REV. 497, 498 (2003) (arguing that mental disorder is "such a vacuous phrase that the law

degree ("serious") and likelihood ("substantial risk") of harm, but not its imminence.[191] This absence of definition could be significant; under the existing standard a person diagnosed with any disorder that creates a long-term risk of dangerous behavior could be committed even if there is no evidence that he will commit a harmful act in the near future. Even more problematic, the non-emergency involuntary standard doesn't define *any* of the three guidelines, but requires only that a need for treatment be found.[192] The addition of "risk of harm to self or others" to this standard in *Scopes*, which the Second Circuit found saved the standard from unconstitutional overbroadness,[193] is similarly vague. [194] By comparison, other courts, including *Lessard*[195] and the Ninth Circuit,[196] have rejected similarly vague state commitment standards as inadequate to justify a police power-based confinement.[197] Oregon courts are similarly strict about how severe the threat to self must be to justify a parens patriae confinement.[198] As the Oregon cases demonstrate, meeting the higher substantive standard will generally require more evidence to be produced,[199]

should consider dispensing with it" altogether and simply identify specific disorders for commitment purposes); *cf.* Am. Psychiatric Ass'n, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS xxi (4th ed. 1994) ("[N]o definition adequately specifies the precise boundaries for the concept of 'mental disorder.'").

191. *See* N.Y. MENTAL HYG. LAW § 9.39(a).

192. *See id.* §§ 9.01, 9.27.

193. *See* Project Release v. Prevost, 722 F.2d 960, 973–74 (2d Cir. 1983) ("[T]he New York State civil commitment scheme, considered as a whole and as interpreted in *Scopes* to include a showing of dangerousness, meets minimum due process standards . . . .").

194. *See supra* Part I.B.2 (discussing the involuntary standard).

195. *See* Lessard v. Schmidt, 349 F. Supp. 1078, 1093 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1974), *reinstated and enforced*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated on other grounds*, 421 U.S. 957 (1975), *reinstated*, 413 F. Supp. 1318 (E.D. Wis. 1976) ("[T]he state must bear the burden of proving that there is an *extreme likelihood* that if the person is not confined he will do *immediate* harm to himself or others." (emphasis added)). The court goes on to define that the degree of harm must be "substantial." *Id.*

196. *See* Suzuki v. Yuen, 617 F.2d 173, 178 (9th Cir. 1980) (overturning a state standard for failing to explicitly require a finding of imminence).

197. *See id.* ("[D]anger must be imminent to justify involuntary commitment.").

198. *See, e.g.*, State v. D.P., 144 P.3d 1044, 1051 (Or. Ct. App. 2006) (holding threat must be of serious harm to self "in the near future").

199. *See id.* (overturning a commitment that had been based on past threats of self-harm and reluctance to take antipsychotic medication, because the state had not carried its burden to introduce evidence of (1) a past pattern of destructive behavior and (2) that the pattern is beginning again); *see also* State v. L.P., 160 P.3d 634, 638 (Or. Ct. App. 2007) (overturning a commitment based on "speculative or conjectural" evidence of imminence). In both of these cases, the Oregon court found

placing a higher burden on the state and restricting a diagnostician's ability to "shoehorn into the mentally diseased class almost any person he wishes."[200] Stricter definitions would thereby reduce the portion of the mentally disabled population who are eligible for involuntary commitment, and New York courts are free to implement them.[201]

### *4. Procedural Standards—Objective Evidence*

In addition to substantive "dangerousness" definitions that determine *what* the state must prove in order to commit, procedural requirements may constrain *how* the state can meet its burden.[202] These procedural requirements entail evidentiary rules that either may be imposed explicitly by statute[203] or implied by judicial doctrine.[204] Most state commitment statutes, including Article 9, require clinical testimony to support a commitment.[205] However, courts and commentators have long observed the general inability of prognostic clinical testimony *alone* to accurately predict dangerousness.[206] This inability is partly a consequence of the inexact

expert testimony by psychiatrists to be too equivocal to prove imminence by clear and convincing evidence; notably, the Oregon statute they were interpreting does not include an imminence requirement, but courts have implied one. *See L.P.*, 160 P.3d at 637 n.4.

200. *See Lessard*, 349 F. Supp. at 1094 (quoting Joseph M. Livermore et. al., *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 80 (1968)).

201. *See generally* Slobogin, *supra* note 190, at 504 ("No less an authority than the U.S. Supreme Court has counseled that judges and legislatures, not psychiatrists or other mental health professionals, should define the scope of legally relevant mental disorder." (citing Kansas v. Hendricks, 521 U.S. 346, 359 (1997))).

202. *See* Ferris, *supra* note 188, at 976 (describing how higher evidentiary burdens can increase the effectiveness of substantive "dangerousness" standards).

203. *See, e.g.*, MONT. CODE ANN. § 53-21-126(2) (2011) (requiring an "imminent threat" to be proven by "overt acts or omissions"); *see also* Alexander Scherr, Daubert *& Danger: The "Fit" of Expert Predictions in Civil Commitments*, 55 HASTINGS L.J. 1, 43 n.210 (2003) (surveying state statutes that require overt acts).

204. *See* Suzuki v. Yuen, 617 F.2d 173, 178 (9th Cir. 1980) ("The proper standard is that which requires a finding of imminent and substantial danger as evidenced by a recent overt act, attempt, or threat." (quoting Suzuki v. Alba, 438 F. Supp. 1106, 1110 (D. Haw. 1977))); *see also* Scherr, *supra* note 203, at 43–49 (surveying judicial doctrines requiring various "overt" and "recent overt" act requirements to support findings of dangerousness).

205. *See* Scherr, *supra* note 203, at 37–40 (surveying statutes and judicial doctrines requiring expert testimony at commitment hearings).

206. *See, e.g.*, Vitek v. Jones, 445 U.S. 480, 495 (1980) ("It is precisely the subtleties and nuances of psychiatric diagnoses that justify the requirement of adversary hearings.") (quotations omitted); *see also* Scherr, *supra* note 203, at 40–41 (concluding that most courts find expert diagnosis alone insufficient to justify

nature of diagnosis itself; medical science in its current state simply is not equipped to foresee an individual's future behavior. It may also owe to professional biases inherent to psychiatrists, who tend to face strong incentives to over-commit disabled individuals who come under their care.[207] These incentives stem from a combination of stereotyping,[208] fear of liability,[209] and treatment bias.[210] Recognizing these strong incentives, other states have imposed evidentiary burdens to restrict physicians' discretion and shift commitment decisions to non-physician fact-finders, namely juries and judges.

Evidentiary burdens take different forms, but generally consist of some additional fact or facts that must be established to provide an objective supplement to clinical testimony.[211] Commentators have proposed requiring actuarial evidence or "structured" clinical evaluation to support the traditional "unstructured" clinical testimony.[212] More commonly, state legislatures and courts will

commitment); Brooks, *supra* note 21, at 269 ("Authorities in legal and medical journals have detailed, with much empirical support, that psychiatrists lack the ability to assess danger proficiently. This lack of skill has resulted in mental health professionals overpredicting instances of harmful behavior."); Phyllis Coleman & Ronald A. Shellow, *Suicide: Unpredictable and Unavoidable—Proposed Guidelines to Provide Rational Test for Physician's Liability*, 71 NEB. L. REV. 643, 644 (1992) ("[P]redictions of the likelihood a specific individual will commit suicide are wrong far more often than they are right.").

207. *See, e.g.*, Perlin, *supra* note 1, at 28–29 (detailing various motivations physicians have to over-commit, including moral concerns and stereotyping).

208. *See id.*; *see also* Bersoff, *supra* note 160, at 336–37 (discussing how heuristic reasoning that characterizes professional assessments of dangerous may cause professional physicians to be "more susceptible to error than . . . trainees and sometimes even lay decisionmakers"); Michael Perlin, *On "Sanism,"* 46 SMU L. REV. 373, 393–96 (1992) (detailing different "sanist" tropes, such as the one that a refusal to take antipsychotic medication indicates dangerousness).

209. *See* Michael Perlin, *Tarasoff and the Dilemma of the Dangerous Patient: New Directions for the 1990's*, 16 L. & PSYCHOL. REV. 29, 57–58, 61–62 (1992) (describing how "litigaphobia" may cause psychiatrists to prefer to err on the side of committing potentially dangerous individuals).

210. *See* Perlin, *supra* note 1, at 28–29; *see also* Brooks, *supra* note 21, at 265 ("[W]hen psychiatrists learn the legal system imposes few constraints on their clinical decision-making, they tend to disregard the law and permit their clinical judgment to dictate how they will act."); Coleman & Shellow, *supra* note 206, at 654 (noting that, even using the most accurate available predictive models, "the physician will predict suicide twenty-five times for every death that will occur").

211. *See* Scherr, *supra* note 203, at 41.

212. *See id.* at 15–22 (describing the relative benefits of clinical assessments, which rely purely on psychiatrists' professional judgment, and actuarial models, which have been empirically shown to be more accurate as applied to groups but not individuals, and advocating that actuarial predictors should be incorporated into clinical assessments to provide an improved "structured clinical" testimony to establish

require objective evidence in the form of an "overt" or "recent" act demonstrating dangerousness.[213] Article 9's involuntary standard, even as read by *Scopes*, does not explicitly require an overt act, and the *Project Release* court declined to require one.[214] The Second Circuit's holding in a subsequent case, *Rodriguez v. City of New York*,[215] may effectively imply an overt act requirement into the standard in some cases by requiring that diagnoses meet with "standards generally accepted by the medical community" in order to satisfy due process.[216] Because compliance with "standards generally accepted by the medical community" is a question of fact, plaintiffs may introduce testimony to show that diagnostic standards require objective, overt evidence of danger to support a diagnosis.[217] In general, however, neither the courts nor the legislature in New York have required objective evidence of dangerousness as a blanket prerequisite to involuntary commitment.

The comparison with rights-protective devices that other states' civil commitment laws employ reveals that New York has chosen to delegate fact finding to physicians and allocate the risk of erroneous commitment to the mentally disabled population to the maximum extent the *O'Connor*/*Addington* framework allows. In the absence of more meaningful substantive and procedural protections, erroneously committed individuals are left to enforce their rights ex post by bringing lawsuits against physicians. As Part III will demonstrate, this form of enforcement has significant limitations, but it may also be a productive way to cut against physicians' incentives to over-commit

dangerousness). Professor Scherr goes on to conclude that predictive psychiatric testimony should still be admitted in commitment hearings, but should be subjected to a *Daubert*-like test for reliability that would likely require some incorporation of objective or actuarial criteria. *See id.* at 88–89.

213. *See supra* notes 203–05 and accompanying text; *see also* Project Release v. Prevost, 722 F.2d 960, 973 (2d Cir. 1983) (noting a split among federal courts on whether an overt act must be shown in order to satisfy *O'Connor*).

214. *See Project Release*, 722 F.2d at 974.

215. 72 F.3d 1051 (2d Cir. 1995).

216. *See id.* at 1062 ("In thus declining [in *Project Release*] to find the statutory scheme as a whole facially invalid in the absence of an overt-act requirement, we did not purport to hold that due process would never impose an overt-act requirement with respect to any particular section of the statute *as applied*." (emphasis added)).

217. *See* Monaco v. Hogan, 576 F. Supp. 2d 335, 349 (E.D.N.Y. 2008) (plaintiffs introduced sufficient evidence to create a triable issue of fact that psychiatrists performing evaluations without considering recent overt acts failed to comport with "standards generally accepted by the medical community").

and indirectly shape a "limiting norm" on the state's power to commit.[218]

## III. CIVIL RIGHTS LITIGATION AS AN ALTERNATIVE BOUNDARY TO ARTICLE 9

In the absence of more protective state law, wrongly committed New Yorkers are left to litigate the adequacy of the substantive and procedural standards under which they were committed in federal court under 42 U.S.C. § 1983 and Title II of the Americans with Disabilities Act.[219] This case-by-case enforcement for damages cannot change the law the way a facial challenge would, but it does give fact finders the chance to examine Article 9's standards as applied. In addition to allowing committees to vindicate their rights individually, these cases set precedent that may indirectly shape the way physicians apply the standards in the future.

### A. Potential Benefits of Case-by-Case Litigation

Civil rights suits for damages provide an incentive to individual committees, and (thanks to fee-shifting statutes)[220] to private attorneys, to litigate the constitutionality of particular involuntary commitments after the fact. This approach can compensate individuals who are swept into the system under Article '9's overbroad standard without requiring action by the legislature or any narrowing of the legislature's discretion by federal courts. Although this strategy does not change the scope of physicians' discretion under the letter of Article 9, it does create the prospect that the methods used to diagnose "danger to self or others" will be called into question in a post-commitment lawsuit. Plaintiffs and private attorneys can present competing expert testimony as to what constitutes "danger" and what kind and quality of evidence can be used to establish "danger."[221] This kind of "battle of experts" comes

218. *See* James J. Park, *The Constitutional Tort Action as Individual Remedy*, 38 HARV. C.R.-C.L. L. REV. 393, 422–23 (2003) (noting the role of constitutional tort actions in forming substantive norms relating "the government's ability to injure").

219. 42 U.S.C. § 12132 (2006) ("[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a pubic entity, or be subjected to discrimination by any such entity.").

220. *See id.* §§ 1988(b), 12205 (allowing courts to award fees to the "prevailing party" in an action commenced pursuant to § 1983 and § 12132, respectively).

221. *See* Rodriguez v. New York, 72 F.3d 1051, 1063 (2d Cir. 1995) ("A rational jury could, for example, reject the proposition that it is consistent with the generally

much closer to the "adversarial" process that the Supreme Court endorsed in *Vitek*[222] than the usual Article 9 hearing in which one doctor, employed by the hospital petitioning for retention,[223] gives all the medical testimony. Allowing a non-physician fact finder to choose between a plaintiff's and a defendant's expert's definition of "danger" combats the influence of physicians' inherent biases. It also makes the adequacy of any particular diagnosis an open question, which gives physicians an incentive to lean toward the "highest common denominator" of diagnostic methods—in other words, the fear of liability could encourage physicians to use the strictest methods and highest standards of "danger" that any expert might credibly espouse at a subsequent trial. Fear of a wider range of post-commitment liability could therefore create ex ante incentives to exercise more care (including longer examinations, different definitions of "conduct" or "serious harm," etc.) to cut against the many incentives to over-commit.[224]

While the Second Circuit has rejected facial challenges to Article 9's standards,[225] it has been more open than other courts of appeals to allowing constitutional claims to proceed against physicians and hospitals that make erroneous commitments.[226] In *Rodriguez v. City of New York*, the Second Circuit adopted an objective professional standard of care for psychiatrists making involuntary commitments.[227] The court allowed a § 1983 claim to proceed to trial where the plaintiff, Rodriguez, had produced expert testimony that her purportedly suicidal thoughts could not constitute "conduct"[228] indicating danger to self, and that the hospital's physician had spent insufficient time with Rodriguez to have made a meaningful

accepted standards of the medical profession to order an emergency involuntary commitment on the basis of 'vague ideation' . . . .").

222. *See* Vitek v. Jones, 445 U.S. 480, 495 (1980); *supra* Part I.A.2.

223. *See* N.Y. MENTAL HYG. LAW § 9.31(c); *supra* notes 142–46 and accompanying text.

224. *See supra* Part II.B.4.

225. *See supra* Part II.B.4.

226. *Compare Rodriguez*, 72 F.3d at 1066 (allowing a claim to proceed to trial to determine based on expert testimony whether physician's conduct deviated from professional standards), *with* Benn v. Universal Health Sys., Inc., 371 F.3d 165, 175 (3d Cir. 2004) (upholding a grant of summary judgment on a similar claim because physician's conduct did not "shock the conscience" as a mater of law).

227. *See Rodriguez*, 72 F.3d at 1065; *see also* Bolmer v. Oliveira, 594 F.3d 134, 144 (2d Cir. 2010) (reaffirming *Rodriguez*).

228. *See Rodriguez*, 72 F.3d at 1057.

diagnosis.[229] Because her expert considered the defendant's brief examination and broad definition of "conduct" to have "deviated substantially" from the standards of the medical community, the court held that a jury was competent to decide that the deviation constituted a violation of her rights under substantive due process.[230]

In a civil rights suit under *Rodriguez*, the proper "standard of the medical community" is a triable question of fact, which at least partly eliminates physicians' discretion to define danger by shifting the question to a "battle of the experts." Other courts have reduced this discretion-checking potential by adopting a "shocks the conscience" standard under which a committing physician's conduct must be egregious or malicious, rather than professionally subpar, to be actionable.[231] This is plainly a much higher evidentiary bar, with the consequence that claims are more likely to fail early on summary judgment. Notably, however, the Second Circuit recently reaffirmed the *Rodriguez* standard, leaving liability for physicians applying Article 9 as a legitimate possibility.[232]

### B. Limitations on Case-by-Case Litigation

The obvious drawback to § 1983 and ADA Title II suits is that, for individuals, these suits can provide only a remedy and do not offer preemptive protection. The specter of liability may indirectly impact physicians' conduct generally, but case-by-case litigation can never have the same protective effect as an elevated legal standard of danger or burden of proof that applies in all cases. For individual civil rights claimants like Ms. Rodriguez, § 1983 can provide vindication but not protection.

Another, more practical barrier to suits against psychiatrists may be the necessity of providing expert testimony. No cost-shifting statute exists for experts under § 1983;[233] nevertheless, expert evidence is generally necessary to create a triable issue of fact under

229. *Id.* at 1056.

230. *See id.* at 1064; *see also* Jensen v. Lane County, 312 F.3d 1145, 1147 (9th Cir. 2002) (importing the *Rodriguez* analysis).

231. *See Benn*, 371 F.3d at 175 (upholding a grant of summary judgment under a "shocks the conscience" test); James v. Grand Lake Mental Health Ctr., Inc., No. 97-5157, 1998 WL 66315, at *7 (10th Cir. Sept. 24, 1998) (same).

232. *See Bolmer*, 594 F.3d at 144 (citing *Benn* and *James* but concluding that "the reasoning of those cases does not persuade us that *Rodriguez* is no longer good law").

233. *Cf.* 42 U.S.C. § 1988(c) (2006).

the *Rodriguez* standard.[234] Plaintiffs wishing to bring a civil rights claim against a hospital must find not only a lawyer willing to represent them, but one with the resources to pay an expert witness.

Finally, it should be noted that New York State has a practice of billing and aggressively countersuing patients who sue its hospitals, usually to collect medical bills that can often be enormous.[235] Even if an ex-patient wins her erroneous commitment suit, she could end up stuck with medical bills that outweigh her award.

## CONCLUSION

As the foregoing examination of Article 9 demonstrates, New York's legislature has chosen to provide minimal constitutional protection to its mentally disabled population's right to be free from unnecessary commitment. The Supreme Court's framework for due process protection, including the broad standards for quality and quantity of proof of "danger" that can justify an involuntary commitment, leaves space for states to delegate commitment authority to physicians. New York's legislature has chosen to do so to a much higher degree than some other states, despite the large percentage of New Yorkers who could potentially be subject to "mentally disabled" status.[236] In particular, by failing to identify what degree of severity or imminence of harm constitutes "danger to self or others" and by declining to require any quantum of objective evidence of mental illness (in the form of an overt act, for example), Article 9's commitment standards leave patients' freedom in the hands of a small group of physicians and potentially at the mercy of institutional bias. So far the Second Circuit, the controlling federal jurisdiction for New York, has been reluctant to directly question Article 9, but has shown a greater willingness than other courts to indirectly affect the commitment standard by leaving psychiatrists open to constitutional tort claims. This can work to patients' advantage, and New York lawyers advocating for the mentally

234. *See* Olivier v. Robert L. Yaeger Mental Health Ctr., 398 F.3d 183, 191 (2d Cir. 2005) (finding that jury was not competent to assess whether commitment deviated substantially from the standards of the medical community without expert testimony); *cf. id.* at 192 (Raggi, C.J., dissenting) ("I do not understand the court today to be holding that expert testimony is an absolute prerequisite to establishing a due process challenge to involuntary commitment.").

235. *See* Allison Leigh Cowan, *Hospitals Send Bill if Mental Patients Win Suits*, N.Y. TIMES, Dec. 24, 2010, http://www.nytimes.com/2010/12/25/nyregion/25damages.html.

236. *See supra* notes 7–11 and accompanying text.

disabled should pursue civil rights suits in order to add a second line of defense to the efforts of Mental Hygiene Legal Services. Until the standards are tightened or medical science gets better at predicting violence, post-commitment § 1983 claims are the best way for New York's mentally disabled population to protect itself from prejudice and medical overreach.